A CASE STUDY OF THE USE OF HYPNOSIS FOR SCHOOL REFUSAL

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Abstract

The intent of this research is to demonstrate the effectiveness of hypnosis as a treatment for school refusal. The research design is a single-case study employing an A-B Follow-up format. The 10 year old male subject completed measures of personality (The Children's Personality Questionnaire), self-concept (The Piers-Harris Children's Self-concept Scale), identified stressors, and anxiety. The baseline period was two weeks and therapy lasted four weeks. Follow-up data was collected on the same measures ten months later. All post-therapy results indicate change in a more adaptive direction. The subject showed increased self-concept, lessened anxiety, greater ability to cope and he returned to school with little or no of the previous psychosomatic complaints evident. The follow-up results show that the subject has maintained his gains. Hypnosis is seen as an effective, fast method of treatment for school refusal, a syndrome which needs to be dealt with quickly since consequences can be severe for the child.

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CHAPTER 1 INTRODUCTION TO THE PROBLEM

School Refusal

Fifty-six years ago, Broadwin (1932) identified a "neurotic" form of school nonattendance that could be differentiated from truancy and parentally-enforced absenteeism. Increasingly the term "school refusal" is used to describe this syndrome since school refusal is not a unitary construct (Granell de Aldoz, Vivas, Gelfand, & Feldman, 1984; Hersov, 1985; Hsia, 1984) and there is a "lack of agreement as to the fundamental nature of the disorder" (Atkinson, Quarrington, & Cyr, 1985, p. 3). The disorder manifests itself when children begin to stay home from school usually because they say they are ill. The refusal aspect is rarely apparent because this behaviour is masked by one or more somatic complaints, for example, headaches, stomach aches, insomnia, and many various ailments - singly or in combination. The appearance of these complaints usually occurs just prior to departure for school. Medical examination reveals no physical etiology and subsequently a psychiatric or psychological referral is made. School refusal has been called the "Masquerade Syndrome" (Waller & Eisenberg, 1980, p. 212) and hypothesized causes have resulted in the terms "school phobia" or "separation anxiety" being used as descriptors for this avoidance behaviour.

Evolution of the Term "School Refusal"

This refusal behaviour was first called "school phobia" by Johnson, Falstein, Szurek & Svendsen (1941). In a follow-up study to the 1941 paper, Estes, Haylett & Johnson (1956) coined the term " separation anxiety" in "an attempt to provide a diagnostic label that more accurately reflected the true locus of pathology" (Waller & Eisenberg, 1980, p. 211) because of the unrealistic worries expressed about harmful things that might happen to parents or the child during the time the child attended school. Separation, rather than fear of school, was seen as the issue in the refusal behaviour (Barker, 1983; Bowlby, 1973; Gittelman-Klein & Klein, 1980; Lawlor, 1976; Prazer & Friedman, 1985). Still others posited fear of failure due to unrealistic self-concept levels (Leventhal & Sills, 1964; Leventhal, Weinberger, Stander & Stearns, 1967) or fear of school (Lazarus, Davidson, & Polefka, 1965; Nichols & Berg, 1970) as the reason. Some think that it is important to draw a distinction between fear of separation and fear of school for treatment purposes (Eysenck & Rachman, 1965; Ross, 1980) yet evidence has not been forthcoming to prove this assertion. Ultimately "school refusal" has become the term of choice (Atkinson et al, 1985; Beeghly, 1986; Hersov, 1985; Kahn, Nursten & Carroll, 1981; Munoz, 1986) although there are dissenters (Berecz, 1969, Reber, 1985). The term does not correspond to a single psychiatric category, yet as a descriptor it has the advantages of emphasizing the essential observable characteristic of the disorder and highlighting the psychosocial

aspect (Kahn et al., 1981). School refusal is not a single clinical entity and it may be part of other neurotic disorders (Snaith, 1981). The point is that school refusal can be the result of school phobia which is an irrational fear of school; separation anxiety, which is fear of loss of attachment to a security figure; or intrahuman variables such as a grandiose view of self or lack of coping skills when anxious and self-preoccupied. It may be impossible to pinpoint cause with certainty yet exploration of subject variables related to the behaviour may be a paradigm to describe effective treatment. We know that school refusal is the observable behaviour of this syndrome (Hersov, 1985) and precipitating factors can be anything that represents a threat to the individual. Under conditions of threat, anxieties and fears are common (Beck & Emery, 1985) and absentee students realize that their distress is almost immediately reduced when they withdraw from the circumstances around which it is generated.

Consequences of School Refusal

The consequences for children who refuse to attend school and who receive no treatment are grim as school refusal's pattern is sporadic absences leading to total absence from school (Hersov, 1985) resulting in disruption and fragmentation of academic instruction. There is some evidence that educational and psychological growth are interdependent since academic achievement and self-concept have been positively correlated (Kawash & Clewes, 1986). Other, not so obvious, negative effects

are that successful school refusal may lead to avoidance behaviour in other situations such as going to a friend's house or participating in community or recreational activities (Brulle, McIntyre & Mills, 1985) although this does not always happen. What is a consistent consequence is that maturation does not solve the problem as children do not outgrow patterns of behaviour involved in school refusal and the effects are more debilitating with increasing maturational demands and social pressure if children are not helped to cope with the increasing stress of the situation. Social demands carry the weight of law since school attendance is compulsory in most countries. There is also the implication that school refusal behaviour is self-destructive (Kahn et al, 1981) and that adult efforts to intervene are ineffective. Children refuse to attend school although parents may persuade, entreat or punish them (Bryce & Baird, 1986).

PURPOSE OF THE STUDY

The effectiveness of hypnosis as a treatment for school refusal was documented by quantitative measures in this single case study. The subject was a 10-year old male fifth grader who had not attended school for three weeks when he was referred to a clinical psychologist for treatment. Prior attendance difficulties had been evident before this full-blown refusal for at least six months.

Reported studies of hypnosis as a treatment for school refusal, as is the case with much research in hypnosis outcome

effectiveness, has been largely anecdotal and outcome assessment has been neglected and ill-defined (Lambert, 1982). This study assessed change over a number of measurable variables to provide direct evidence that during the period of treatment there was a quantifiable move toward more positive adjustment as regards school attendance, anxiety, and self-concept leading to more effective coping behaviour. Both criterion-referenced and normative data were collected to document and estimate the degree of change.

Hypotheses Tested

Stated in the Null form, the hypotheses this case study investigated were:

1) Hypnosis will have no effect on school refusal behaviour as measured by school attendance and parent reports.
2) There will be no change in self-concept as measured by The Piers-Harris Children's Self Concept Scale.
3) There will be no change in anxiety as measured by the Children's Personality Questionnaire (CPQ), The Piers-Harris Children's Self Concept Scale, and The Anxiety Acceptance Scale, The Coping Effectiveness Scale and Personal Stress Level.
4) There will be no change in somatic complaints as measured by Personal Stress Level and parent reports.

Rationale

Few studies have been conducted where school refusal was treated by hypnosis. These reports are largely anecdotal accounts which do little to isolate essential variables for change. This study used a single system design in an attempt "to monitor problems continuously to determine whether or not the problem actually changes" (Nugent, 1985, p. 192) as well as to try to determine if causitive relationships existed between the intervention and observed change.

A single case design was chosen to evaluate hypnosis as a treatment for school refusal because repeated measures in this framework can help establish a knowledge base about individual responses over time and allow for the analysis of individual variability. It also provided information about the need for treatment adjustment and refinement (Kratochwill, Mott, & Dodson, 1984). "The A - B design, with stability information... seemed particularly well suited for use with hypnotic interventions" (Nugent, 1985) and a single case design with repeated measures increased the validity of causal inference (Kazdin, 1982).

Standardized pre and posttests of personality and self-concept are measures used to provide psychometric evidence of change in critical variables associated with school refusal. Since these were collected at the three crucial points of entering treatment, leaving treatment and after a 10 month follow-up period, they indicated change stability which is an important factor in assessing treatment effectiveness.

Limitations of the Study

Results from single case studies are not generalizable because more than one subject is needed to get an estimate of inter-subject variability within the population. Furthermore measurement is always in error and all instruments are less than perfect, therefore cautious interpretation of the results is essential and must also be made in context of the known information about the instruments used. In this study, only part one of each CPQ form was administered at each session. Therefore, the results were interpreted as directional markers rather than attainment levels.

Another consideration was that observations in a single case study are not strictly independent and this limits the statistical choices for the researcher. In this study, significant clinical outcomes precluded the generation of sufficient data points to do a time-series analysis which is a design strategy that would have increased statistical inferential capacity. An A - B Follow-up format was used with a 2 week baseline due to the severity of the problem and the urgency for treatment as outlined by the parents.

Basically this study confirmed the effects but it could not delineate the mechanisms of treatment. It demonstrated that target variables had been modified but could not specify which aspect of the treatment was crucial so the therapeutic procedure was accepted as a whole. The general impact level of this intervention would justify the case study despite the above considerations.

CHAPTER 2 LITERATURE REVIEW

SCHOOL REFUSAL - Terminology

In the early 1930's, Broadwin (1932) recognized a neurotic form of school absence which differed from truancy. For this group of children, much anxiety was attached to school attendance. Johnson et al (1941) coined the term "school phobia" to describe an anxiety reaction in children that resulted in their persistent absence from school. These earlier studies focused on the theoretical etiology with the consequence that this condition, which had the same presenting problem, was described in various different ways. The most common were "school phobia", "separation anxiety" or "grandiosity". Waller & Eisenberg (1980) proposed the behavioural descriptor "inappropriate homebound school absence" (p. 210).

In other words, these children presented a varied clinical picture and often the label depended upon the therapist's training and orientation. School refusal has been viewed as a single syndrome that presents with a variety of symptoms (Frick, 1964) and "as a variety of syndromes with a common presenting symptom" (Atkinson et al., 1984, p. 83). One author has dealt with the problem of terminology by conceptualizing school non-attendance "as a continuum with progression from 'involuntary' symptoms on one end to 'willful' refusal on the other end as time elapses" (Hsia, 1984,p. 361). She envisioned the early stages as school phobia and the later stages as school refusal.

If one attempted to use the Diagnostic and Statistical Manual's diagnostic system - DSM-lll-R, (American Psychiatric Association, 1987), the best fit may be between over anxious disorder and separation anxiety. Individuals may fit into different categories and yet have the common problem of school refusal (Snaith, 1981). There are further compounding problems because in most countries, unless there are valid medical reasons, school attendance is mandated by law (Kahn et al., 1981), thus making this a psychosocial problem (Skynner, 1974). In researching this subject, it was necessary to include the literature on school phobia and separation anxiety as these earlier terms have wide acceptance. School refusal is "a more inclusive term since it covers all cases where there is a psychosocial component" (Kahn et al., 1981,p. 3). The term "school refusal" has further merit in that it does not force one to adhere to a particular theoretical orientation yet it allows for consideration of the whole child in a context where the impact of both home and school can be weighed (Hersov, 1985). In this paper, the term "school refusal" was used except where specific references used school phobia or separation anxiety.

INCIDENCE

There have been no direct investigations of the prevalence of school refusal (Trueman, 1984b). Different figures have been cited in articles; the most common of which is 17 per 1000 clinical cases (Kennedy, 1965). This claim is unsubstantiated and the basis for it was unreported but as Trueman (1984b)

pointed out this figure would mean that "one of approximately every 59 children is school phobic" (p. 193). A study, which attempted to investigate this topic in a more systematic manner, used these criteria: the child was absent from school more than one standard deviation above the school norm and parent, teacher and self-reports agreed that the child was highly fearful. The range was .4 (total agreement) to 1.5 (agreement of child or parent report) in this sample of 1034 Venezuelan children from 3 to 14 years of age (Granell de Aldaz et al., 1984). In their analysis of ten cross-cultural studies, they concluded that prevalence rates varied with "population characteristics, the methodology applied and criteria selected (p.723). Ranges from 1% to 8% have been reported from various child guidance clinics (Beeghley, 1986).

The true extent of school refusal may never be exactly assessed because not only do many different referral agencies deal with these children but the problem is further compounded because those children, who exhibit mild symptoms, may be effectively treated within the school situation by the school counsellor and never become a statistic from a mental health clinic or a hospital (Sugar & Schrank, 1979). Another difficulty in accurately assessing numbers stems from the fact that somatic complaints are often the reason a physician's diagnosis is sought. If the adult makes no reference to the child's nonattendance at school, the school refusal behaviour may go unnoticed (Waller & Eisenberg, 1980). Despite the difficulty of obtaining precise figures, it is reported to be a common problem

which poses significant therpeutic management problems (Trueman, 1984a). Indeed, acute school refusal is seen as a true child psychiatric emergency (Derogatis,1986; Prazer & Friedman, 1985).

CHARACTERISTICS ASSOCIATED WITH SCHOOL REFUSAL

Much has been written about school refusal. Age, gender, socio-economic levels, familial patterns, school achievement, extensiveness of disturbance, precipitating factors, and personality characteristics are some of the variables that various authors have hypothesized as useful in understanding school refusal (Atkinson et al., 1985; Trueman, 1984b).

Age

Age of onset is distributed bi-modally with the greatest incidence at age eleven (Baker & Wills, 1978; Marks, 1978) and again, at school entrance, usually between the ages of five and six. Age of onset and extent of pathology are often linked since later onset is equated with greater pathology (Kennedy, 1965; Hersov, 1960a; Coolidge, Hahn, & Peck, 1957). However, there is no experimental evidence for such a dichotomy and many authors believe that the difference is more a matter of degree than of kind in that school refusal is seen as a continuum (Atkinson et al.,1985; Hersov, 1985; Trueman 1984b). To account for the fact that there are older school refusers who have attended school successfully for several years, it has been proposed that increased stress may be the most likely precipitating factor (Baker & Wills, 1978). Although the capacity to cope with stress

varies with age, preadolescents and adolescents have a great many stressors - developmentally, socially and academically. If this syndrome is a continuum, this may be the point where certain children may be unable to maintain successful attendance. "Very often, school refusal is one indication of the young adolescent's general inability to cope with the increased demands for an independent existence outside the family and entry into normal peer group relationships" (Hersov, 1985, p. 384). School refusal in adolescents is also seen as panic in facing development (Coolidge, Willer, Tessman & Waldfogel,1960).

Gender

Gender issues are often noted in studies of school refusal and it is difficult to draw any real conclusions as there have been "no systematic assessments of the proportions of boys and girls with school phobias" (Trueman, 1984b, p. 194). There have not been any meaningful attempts to delineate sex differences in personality, attitudes towards school or other relevant variables in the school refusal population. Several investigators had more boys in their samples (Baker & Wills, 1978; Berg, Butler & Pritchard, 1974; Hersov, 1960a; Rodriquez, Rodriguez & Eisenberg, 1959). Other studies had a greater proportion of girls (Gittelman-Klein & Klein, 1973; Nichols & Berg, 1970; Berg, Nichols & Pritchard, 1969). However, Hersov (1985), in a thorough review, concluded the occurence of school refusal is "equal for both sexes" (p. 384). This was also the conclusion of the Venezuelan study (Granell de Aldaz et al.,

1984). Atkinson et al. (1985), in their review of the literature, reported differences in boy's and girl's attitudes, amount of antisocial behaviours displayed and family interaction patterns. There was little experimental evidence to support these conclusions and when there was, confounding variables and test results which were not significant did little to clear up questions as to how gender relates to school refusal.

Socio-economic Status

Socio-economic status (SES) was mentioned in an early study by Talbot (1957) when it was pointed out that this study had a high proportion of upper to middle class subjects which was accounted for by the location of the clinic. Since then, it has been a prevailing notion that "school phobia was more endemic to higher socio-economic groups" (Trueman, 1984b,p. 194). This has not been borne out in subsequent examinations. One study used social class to classify school refusers and found no significant differences between the upper and lower groups but a higher SES trend was noted (Baker & Wills, 1978). In a study, which used a control group, the school refusal group had a lower SES but the statistical significance was not reported (Nichols and Berg, 1970). School refusal rates were found to be significantly higher for children "attending public and lower SES schools" in Venezuela (Granell de Aldaz et al., 1984, p. 728). With such fragmentary and contradictory evidence, it is impossible to say that there is a relationship between SES and school refusal.

Familial Patterns

Family patterns and dynamics of school refusers have been discussed and examined by various researchers. In reporting on acute school refusers, it was found that they were likely to be the youngest child in a small family (two or fewer siblings), their mothers tended to be older and the age of onset was later (Baker & Wills, 1978). Bowlby (1973) noted four main family patterns in school refusers: 1) The mother and, sometimes the father, suffer from chronic anxiety regarding their own parents and want the child to be home for companionship; 2) the child is afraid something will happen to either parent and stays home to prevent this; 3) the child is scared that he may get hurt and stays home where it is safe; 4) either parent may be fearful that some harm will come to the child and they wish him to stay home. Bowlby (1973) found the first pattern to be the most common one in school refusal. Families of school refusers have been described as neurotic (Harris, 1980; Talbot, 1957); with a disproportinate balance of power (Hsia, 1984; Coolidge et al., 1960) and as either overinvolved or underinvolved (Hersov, 1960b).

Hersov (1960b) saw three main types of parent-child relationships - a) an overindulgent mother and passive father with a willful demanding child while at home yet fearful and timid outside; b) a severe, controlling, demanding mother and a passive husband with a passive, obedient child at home who became fearful and timid when outside the home; c) a firm, controlling father and an over-indulgent mother. She is close to

her child who is willful, stubborn and demanding at home yet who may be friendly and outgoing away from home. In a follow-up study of previously hospitalized school refusers, former school refusers saw their mothers as overprotective or they had unresolved attachments to their mothers (Weiss & Burke, 1970). From a family systems point of view, school refusal can have both a protective and stabilizing function within a pathological family system (Hsia, 1984).

Intelligence and Academic Achievement

Early studies usually stated that school refusing children are average to above-average in intelligence but this was based mainly on clinical impressions rather than on collected data (Trueman, 1984b).There seems to be a general impression that people with psychiatric disorders have a lower IQ than the rest of the population but evidence for this is inconclusive (Beitchman, Patterson, Gelfand & Minty, 1982). Case studies have reported evidence of learning disabilities in school refusers (Suttonfield, 1954) and low achievement despite average intelligence (Miller, 1972). A study of children in residential treatment found that school achievement was the best area of hospital adjustment (Weiss & Cain, 1964).There have been no significant differences reported in the scores of acute versus chronic school refusers (Baker & Wills, 1978; Berg, Nichols & Pritchard, 1970; Nichols & Berg, 1970) but school refusers in general were overachievers of at least average intelligence (Hersov, 1985). In a follow-up study, school achievement was

found to be high but social adjustment was low. Involvement with school work was often used as the rationale for having few or no friends (Weiss & Burke, 1970).

In one systematic study of the IQ scores of school refusing children, the mean Full Scale IQ score on the Wechsler Intelligence Scale for Children was 98.9; the mean Verbal score was 96.7 and the mean Performance score was 101.6 indicating that this group of fifty-seven children scored in the average range for this test. IQ equivalent scores were lower on an achievement measure (Wide Range Achievement Test) leading the authors to conclude that these children were not performing to their potential (Hampe, Miller, Barrett & Noble, 1973). Evidence is mixed and does not support the notion that school refusers are homogeneous as far as intelligence and school achievement are concerned.

Extensiveness of Disturbance

Most writers now acknowledge that school refusal is a condition associated with a range of behaviours, that is, it is not a single clinical entity (Hersov, 1985). Extensiveness of disturbance was correlated with age of onset, so early researchers tried to dichotomize school refusers into discrete categories since there are two distinct groups - those whose school attendance ceased abruptly and those whose school refusal developed slowly over time (Kahn et al., 1981). One attempt used the labels "neurotic" and "characterological". The former group had an abrupt onset usually after several trouble-free years of

school attendance. With the onset of school refusal, behaviour at both home and school had changed but despite this, their social and intellectual functioning was unimpaired. This group had a better prognosis than did the characterological type who were more disturbed and more generally fearful (Coolidge et al., 1957). Later these groups were relabelled Type 1 and Type 2 school refusers and ten criteria were suggested for use in discriminating between them (Kennedy, 1965). The process used to devise these was not explained and a very small sample of Type 2 (characterological) school refusers was used (Atkinson et al., 1985). Other studies show that the characterological, or the more deeply disturbed group, can be further divided on the basis of family dynamics (Weiss & Cain, 1964; Hersov, 1960b). Hersov's first two family descriptions, as described earlier in this paper, are associated with this group for whom school refusal is only one signal that the child is more deeply disturbed. It would appear that school refusal sometimes indicates a syndrome wherein the child is temporarily affected and his basic personality remains intact, and for others it denotes a more all-pervasive condition of greater pathology.

In working with 63 file cases of highly anxious school refusers, Smith (1970) distinguished three groups. They were: 1) young children who manifested fears at an early age, who tended to encounter these difficulties repeatedly, and were seen as suffering from separation anxiety; 2) older children who had not had previous school difficulty. These were seen as "school phobic" and were also generally seen as phobic outside of

school. Not all these children could identify a feared school situation rather they were described as generally fearful and timid; 3) older children who appeared depressed or who showed signs of fear of failure or rejection. These children were also perfectionistic. None of the syndromes was believed to be mutually exclusive.

Precipitating Factors

As might be expected, examinations of events which lead to school refusal also revealed mixed and sometimes contradictory findings. There would appear to be a myriad of events which activates avoidance behaviour in connection with school. A study of sixteen school refusers revealed that two-thirds had a discernible precipitating event such as a move to a new school, entrance to junior high school, hospitalization of the child, illness of the mother or child or a death in the family. For the remaining one-third there was no apparent reason (Weiss & Cain, 1964). Others have mentioned "overwhelming threats to the child's security" (Hsia, 1984, p. 361); separation anxiety (McDonald & Sheperd, 1976; Bowlby, 1973); and anxiety avoidance (Eisenberg, 1958). One study, stated that a "significantly larger number of acute cases had known precipitating factors" (Baker & Wills, 1978, p. 495) whereas chronic school refusers usually did not. Despite the fact that two of the three theoretical models used to explain this phenomenon place great importance on precipitating events, there has been very little research done in this area. There have been no studies which

assessed the school situation (Trueman, 1984b). Hersov (1960b) studied 50 file cases and abstracted the explanations given by the children for their refusal to attend school. The responses fell into three groups: 1) fear of harm coming to mother; 2) fear of the teacher or other pupils; and 3) fear of academic failure.

PERSONALITY AND SCHOOL REFUSAL

In its earliest inception, school refusal was viewed as a symptom of a personality problem described as "a neurotic character of an obsessional type" (Hersov, 1985, p. 382). Since then, various personality dimensions have been observed in this group of children. Besides being described as anxious and neurotic, these children were also seen as dependent (Blanco, 1982; Trueman, 1982b). Results of an experiment designed to uncover more about school refusers and dependency reported that the chronic subgroup showed greater dependency characteristics than the acute subgroup (Berg et al., 1969). "Acute" meant at least three trouble-free years of continuous attendance.

Another strand of personality descriptors which runs through the literature depicts these children as willful, manipulative and grandiose at home yet shy and fearful at school (Leventhal & Sills, 1964; Leventhal et al., 1967). These children were high achievers who had an inflated sense of self. When they could no longer "maintain their narcissistic self image" (Leventhal & Sills, 1964, p. 686)
because the reality demands of school deflated it, they avoided

school. Studies have not provided support for this hypothesis (Berg & Collins, 1974; Berg et al., 1969).

Anxiety and School Refusal

Anxiety is a defining characteristic of school refusal behaviour (Barker, 1983; Beeghly, 1986; Blanco, 1982; Coolidge et al., 1960; Gittelman-Klein & KLein, 1971; Klein, 1980; Smith, 1970) and school refusal has been called "the most frequent form of anxiety in children" (Crasilneck & Hall, 1985, p. 241). However, pharmacological reduction of anxiety in school refusing children did not lead to an automatic return to school (Gittelman-Klein & Klein, 1971 & 1973). Other studies reported that anxiety impairs cognition (Crowne, 1979; Sarason, Davidson, Lighthall, Waite & Ruebush, 1960); interferes with concentration (Decker, 1987); is involved with self-esteem expression (Kawash & Clewes, 1986); and may be "that something that mediates avoidance behaviour" (Ross, 1980, p. 146). Phillips (1978) suggested that anxiety caused children to undergo basic personality changes which led to two debilitating behaviours - 1) self preoccupation and 2) avoidance behaviours. Experimental evidence showed that anxious children regress to a primitive level of perceptual functioning when presented with contradictory sensory experiences which are beyond their level of cognitive maturity (Smith & Danielsson, 1982) and one implication of these studies is that overly anxious children operate more comfortably in a regressed state than one commensurate with their developmental level.

Self-Concept and School Refusers

Rutter (1984) envisioned personality development occurring in a social context and "social cognitions provide an important part of personality functioning" (p. 316). Difficulties with peer relationships often typify the school refuser's social orientation (Hersov, 1985; Weiss & Burke, 1970; Weiss & Cain, 1964) though this is not always true (Davidson, 1960). Normal patterns of socialization are disrupted and, because of this, dependent behaviours may be reinforced. It was hypothesized (Dielman & Barton, 1983) that dependence leads to frustration which leads to aggression toward self which in turn leads to low self-concept. Low self-concept has been reported in school refusing children (Hersov, 1985; Hsia, 1984). Healthy relationships and positive reinforcement for learning help determine self-esteem - the evaluative component of self-concept (Sniderman, 1983). Unhealthy relationships both familially and with peers seem to be the case with children who refuse to attend school (Berg, Butler, & Hall, 1976; Bowlby, 1973; Hersov, 1985 & 1960b; Kahn & Nursten, 1962; Talbot, 1957).

TREATMENT

Major Theories Associated with Treatment

Studies have described treatment procedures based on various theoretical formulations mainly psychoanalytic, psychodynamic and learning theory (Atkinson et al., 1985). The psychoanalysts use the concepts of fixation and regression when

they describe the school refuser's strong attachment to the nourishing figure and their desire to return to an earlier state of dependency where they were so nurtured. Often it is the mother to whom the strong bond is formed. Adaptational and social pressures push for differentiation and striving toward independent actions. The child's struggle with these opposing forces may be threatening for either or both mother and child. Thus psychoanalysts favour separation anxiety as an explanation for school refusal (Bowlby, 1973).

Psychodynamic theorists refute this because of the later age of peak prevalence of school refusal and they focus primarily on the aspect of the child's overinflated self-image which lessens ego strength preventing the child from coping with the reality demands of school. Fear of failure may be the overriding emotion in this conceptualization (Leventhal & Sills, 1964).

Learning theorists see phobias as learned responses and fear-inducing stimuli must be identified as part of the treatment. Therefore it is considered important to discuss whether the fear is of the school environment or of leaving home (Eysenck & Rachman, 1965). Behavioural techniques that are commonly used are relaxation and systematic desensitization.

These views are not necessarily discrepant as they "may involve differences of focus rather than substance" (Atkinson et al., 1985, p. 86). Whatever the theoretical underpinnings, it has been recognized that school refusal is "often a difficult and taxing problem to treat" (Bryce & Baird, 1986, p. 199).

Recently, there has been renewed interest in biological aspects of this syndrome. There have been reports of unusual sleep and wakefulness cycles in school refusers (Jackson, 1964; Talbot, 1957). One case study (Fukuda & Hozumi, 1987), found that direct manipulation of the circadian system reduced the level of filial violence in a male school refuser.

Hypnosis - Theories and Definitions

Hypnosis is still a controversial subject "despite more than 200 years of use" (Wadden & Anderton, 1982, p. 215). In attempts to define this phenomenon, hypnosis has been described as communication with the unconscious (Barnett, 1981), mental passivity (Bowers, 1982), an altered state of consciousness (Grinder & Bandler, 1981), and a "natural learning process which is psychologically complex" (Kohn, 1984, p. 4). Some writers describe hypnosis as an antecedent condition and focus on what the therapist does to convince the client and him/herself that hypnosis is being used. The important behaviours here are using a formal induction and labelling the treatment as hypnosis. Others define it in terms of client behaviours such as hypnotic susceptibility. Described this way, hypnosis is a dependent variable (Wadden & Anderton, 1982). In the first case, hypnosis is not seen as a treatment method but as a technique to help motivate the client and increase the effectiveness of the therapeutic intervention (Kohn, 1984). In the latter scenario, hypnosis is viewed as a state wherein there is a narrowing of attention, anxiety alleviation, reduction of normal planning

facilities as the passive client tries to please the hypnotist, exhibits enhanced ability to express repressed or dissociated material, and has the ability to control involuntary physiological responses (Kohn, 1984; Reber, 1985). There is some tentative evidence that hypnosis is more effective when it is individualized to suit the client (Clarke & Jackson, 1983; Hammond, 1985; Holroyd, 1980).

Hypnosis and Children

Research on the hypnotizability of children suggests that hypnosis is a very effective technique when used with children - especially between the ages of 7 to 14 (Ambrose & Newbold, 1980, Cooper & London, 1979; Gardner, 1974; London, 1962; London & Cooper, 1969; Morgan & Hilgard, 1979). It has even been suggested that hypnosis is more effective with children than with adults (Johnson, Johnson, Olson & Newman, 1981). Medical and surgical problems, emotional and behaviour disorders, and learning and school-related disorders are three areas where hypnosis with children has had extensive research indicating the effectiveness of the technique (Gardner, 1974). Very few studies, however, describe treatment for school refusal with hypnosis. Three case studies using a hypnotic intervention with "school phobic" children were reported by Lawlor (1976). Hypnosis was used to achieve "meaningful communications and to bring fears to consciousness so that they could be discussed and faced" (Lawlor, 1976, p. 75).

CHAPTER 3 METHOD

Introduction

Treatment for the 10-year old school male refuser was hypnosis. The therapist had been in practice since 1974 and had extensive experience working with children. The techniques used are described in detail so that replication is possible. One reason why hypnosis may be useful is that it reduces anxiety (Kohn, 1984) and renders other therapeutic techniques more forceful (Gaunitz, Unestalh, & Berglund, 1975; Matheson, 1979). Treatment variables controlled by the therapist were: 1) the therapist's language; 2) the setting; and 3) data collection.

The Subject

The subject was a 10-year old caucasian male in Grade 5, the youngest of two male siblings. He had not attended school for three weeks when he was referred for treatment to a clinical psychologist. For six months prior, the subject had gone through a period of complaints of headaches, stomach aches, insomnia and increasing school absence. Typically, he would have difficulty falling asleep and would wake up two to three hours before the alarm clock rang. He would wake his mother who would talk to him and, until his ultimate refusal, could get him to go to school with much persuasion. He blamed his health, his lack of friends, his classroom situation (he was in a combined Grade 5/6 class) and his inability to cope with math and reading comprehension when asked why he could not go to school. He was examined by the

family pediatrician who could find no physical cause for the various complaints.

Father is a company executive and mother is a homemaker. Their socioeconomic status is upper middle-class. The subject has one brother who is two years older and who excels in academics and sports. All nuclear family members are avid athletes and strong competitors. The subject was the top-ranking track and field contestant for his age in his school division the previous spring. He is well-formed and attractive in appearance. His report card marks are usually in the high average range (B to B+ on a 5-point scale A, B, C, D, F where C is average) despite his view of having difficulty in specific school subjects. There was no history of school refusal but his mother reported that he was timid in approaching most new situations and somatic complaints had previously interferred with school attendance.

To place the subject within the conceptual framework provided by the literature on school refusal, various aspects are clear. He would be identified as being classed as "acute" near the most frequent age of onset. His previous length of regular attendance as well as being the youngest in a small family, which are defining characteristics of this grouping, would qualify him for the label. Though described as less serious as far as development is concerned, acute school refusal rarely disappears without intervention (Hersov, 1985) and the prognosis is less favourable as time goes on.

The reason for the school refusal was unclear. His

reports of precipitating factors center around school. His fear of academic failure coupled with anxiety about being in a combined grade class make it appear to be a phobic reaction. On the other hand, he stayed close to his mother and appeared calmer when she was present. From this behaviour. one could infer that separation also plays a role in his unwillingness to go to school.

Pre-Therapy Procedures

In this phase of treatment, rapport was established as well as the identification of problematic thoughts and areas of worry for the subject, that is, where the subject defined the personal meaning of thoughts about himself and events (Beck, 1976). Rapport, "a comfortable, relaxed, unconstained, mutually accepting interaction between persons" (Reber, 1985, p. 609), was established by providing an accepting environment, pacing, empathic reflection, explaining therapeutic procedures and obtaining the subject's verbal consent to undergo therapy. Acceptance was shown by believing the child and seeking his permission. Pacing is noticing behaviours, breathing, rate of speaking and matching them to build an "unconscious biofeedback loop" (Grinder & Bandler, 1981, p. 14). Empathic reflection is paraphrasing the content and affect in a subject's statements to let him know that he is being heard and understood. The subject was told that together he and the therapist would talk about what worried the child and they would write his worries down so they could be used to assess change. Other measures would be

taken at the beginning and at the end of treatment as well as at a later date. The subject was asked if he could do this and if he consented to do it. The reply was in the affirmative. He was also asked if he wanted his mother to be present during therapy. The subject replied that he did.

Since changing the manner in which an individual conceptualizes his world lies at the heart of the therapeutic procedure and the aim was to extend, modify, and relearn behavioural patterns to facilitate coping in anxiety-producing situations, especially school, the subject's day-to-day stressors were identified and scaled. The subject's level of anxiety acceptance, view of problem severity and ability to cope were also measured. Assessments of self-concept and personality, both of which included anxiety scales, were administered during this two week period and are pre-treatment measures. The self-report data constituted the baseline phase. Though desirable, it was not in the subject's interest to extend the baseline phase because of the imperative for an early return to school.

Dependent Measures

The design generated two kinds of data. One type was criterion-referenced wherein the subject was not compared to a representative group but compared to criteria related to himself. These were self-report measures developed between the therapist and the subject. From the initial interview, a self-report scale, called Personal Stress Level, was constructed

to measure subject-identified complaints. The areas were somatic complaints, academic and social issues plus a statement about general anxiety. Each was rated on a Likert Scale and this 1 to 5 scale was used to aid the subject to recognize change (Appendix A).

Three other scales administered were anxiety acceptance, problem severity and coping effectiveness. These were adopted with pairs of bipolar adjectives or adjectival phrases (Ishiyama, 1986). Each had seven empty spaces in between and were scored from 1 to 7 in the appropriate direction with the total score being used for each scale (Osgood, Suci, & Tannenbaum, 1957) (Appendix B). This is a form of the Semantic Differential Technique.

Two standardized, norm-referenced measures were administered pre and posttreatment and after a 10 month follow-up period. One measure was the Piers-Harris Children's Self Concept scale - "The Way I Feel About Myself" (1984) which comprises six item-clusters: behaviour, intellectual and school status, physical appearance and attributes, anxiety, popularity,and satisfaction. The reliability of these scales has been questioned (Platten & Williams, 1979) but recent reliability studies have placed internal consistency from .88 to .93 (Kuder-Richardson 20) on the total scale (Jeske, 1985). When results are integrated with other data regarding the individual, it is seen as the "best children's self-concept scale currently available" (Jeske, 1985, p. 1169). Scores between the 31st and 70th percentiles are considered average. The manual notes that

"high scores may reflect positive self-evaluation or a healthy desire to look good in front of others, and may not be a cover for underlying problems" (Cosden, 1984, p. 516; Piers, 1984). This test gives information on the social and affective states of children in Grades 4 to 12.

As well as the six cluster scores, there is a total self-concept score which is based on the assumption that a unitary score can represent how one feels about oneself in relation to peers in a global way. The mean for the total test is 51.84 and the standard deviation is 13.87 (Piers, 1984).

The other standardized measure used was the Children's Personality Questionnaire (CPQ) "What You Do and What You Think" by B. Porter and R.B. Cattell (1975 edition). This is a personality inventory for children between the ages of 8 and 12 along 14 dimensions of personality which were derived through factor analysis and found to be factorially independent. Each scale has a technical name as well as an alphabetic reference symbol. "Specifically, the test has been used in clinical child psychology to identify and understand anxiety, neuroticism, and delinquency" (Drummond, 1984, p. 196). Raw scores are transformed to Stens which are a special case of standard scores. These scores use a standard ten scale and are derived from a linear transformation of the z-scale. The range is 1 to 10, the mean is 5.5 with a standard deviation of two (Porter & Cattell, 1975). There has been some criticism that there is a lack of equivalence among forms and also that factor homogeneity and stability are lower than might be expected so the

reliability of this test on an individual basis may be affected (Drummond, 1984).

Therapeutic Procedure

Treatment was scheduled for 60 minutes once each week in the psychologist's office. After the two week baseline data collection phase and first treatment session, all other data was collected prior to trance induction so that post-hypnotic effects would not account for measured changes. The four treatment sessions followed the same format. For about 20 minutes, discussion centered around subject-identified stressors, coping ability, and problem severity. Then rating took place. The hypnotic intervention occupied the following 20 minutes. Finally, there was discussion and feedback about the session. The subject was reminded to play the audio tape at bedtime.

The subject sat in a comfortable reclining chair opposite the therapist. Mood music played in the background and the room was dim. His mother sat behind and about two metres from the subject. The subject was told he could close his eyes or leave them open and to focus attention on his breathing as well as other physical sensations (Appendix C). A trance was induced by means of pacing, systematic relaxation, and using sensory-based non-specific language (Grinder & Bandler, 1981). The subject was told that he could respond in a normal voice to questions while under hypnosis.

He was told to imagine himself going to to the

therapist's other office where the subject would find what he needed to make changes for himself. The subject was asked to construct exactly what he saw in the office, how it was furnished, decorated and what it contained. The therapist told him there was also special equipment such as a talking computer and a beam of white light which had healing powers. The subject was told that as he lay in the chair in the imaginary office the beam of light would pass over him and work with his own bodily processes to provide healing so that his headaches and stomach aches would disappear and that his nightly sleep would be uninterrupted. The light would work as naturally as his breathing or his heart beating, thus anchoring a feeling of well-being with naturally occurring bodily processes which become conscious from time to time. "Anchoring refers to the tendency for any one element of an experience to bring back the entire experience" (Grinder & Bandler, 1981, p. 61). Posthypnotic amnesia was introduced because the subject was told he did not have to remember everything, only the feelings of health and well-being when he became aware of his breathing or his heart beating.

The talking computer was used in conjunction with the procedure called " The New Behaviour Generator" (Grinder & Bandler, 1981, pp. 178 - 200). The behaviour selected for change was going to school. Instructions to the subject directed him to see himself going to school on the computer and to listen to what he was telling himself. When he could watch this dissociated image comfortably, he told the therapist by giving a

prearranged "yes" signal.

The next step directed the subject to choose preferred behaviour in this situation. When the subject indicated that he knew what behaviour response he would make, he was instructed to watch and listen to himself making the new response of going successfully to school on the talking computer. The therapist checked to see if the subject was completely satisfied with this image. A "no" answer led to having the subject make refinements in the dissociated image until he was sure he felt happy with it. Once these adjustments were in place, the therapist instructed the subject to put himself inside the computer image and carry out the behaviours in the situation as if he were actually doing them. This was rehearsed until the subject could signal "yes" he could satisfactorily accomplish this behaviour and that he felt good doing it.

To be sure that this changed behaviour transferred automatically to real life, future-pacing or bridging was used. In this technique, the unconscious mind was asked if it would take responsibility for having this new behavior actually take place and get the subject successfully to school. The subject was asked to see, hear, and feel specifically what would occur on the way to school. Then he was asked to signal "yes" when he could make this behaviour occur and his unconscious mind would vouch for his being able to do this in real life.

Covert positive reinforcement (Cautela, 1979) was established through imagery conditioning, and the desired adaptive responses to the school situation were reinforced by

associating them with an imagined pleasurable stimulus. In this phase, upon induction of hypnosis, the subject was to imagine a time and a place where he felt in control, confident and capable. He chose running. Then he was told to imagine all the pleasurable bodily and thought sensations he could associate with running and to combine them into an overall feeling. When the subject said he could do this, he was to transfer himself in imagery to the school and, as he progressed to his classroom, at various stages he rewarded himself with his confident capable feelings. When he could do this in different settings such as in the school yard, going through the door, going to his classroom, sitting in his desk, etc., then he rewarded himself in imagined meetings with friends as well as in successfully completing math and reading comprehension activities.

An audio-tape was made of the hypnotic content of the session and the subject was instructed to listen to it at bedtime.

CHAPTER 4 RESULTS

First Hypothesis

As treatment came to its conclusion, the subject attended school regularly and continued this behaviour for the last two months of his grade 5 school year. Subsequently, as the new term commenced, he was able to go to school on a continuing basis with no reoccurrence of the school refusal behaviour. Parent reports and school attendance records verified this change. The first hypothesis was rejected as stated in the Null form.

Second Hypothesis

Pre-treatment assessment on the Piers-Harris Self Concept Scale resulted in a score at the 17th percentile. At treatment conclusion, the score was at the 99th percentile where it remained as shown by the 10 month follow-up assessment scores. Results generated from the Significant Change Formula (Christensen & Mendoza, 1986) (Appendix D) showed a significant difference between the pre and posttest scores at the 0.05 level on a one-tailed test. This indicated that the subject had moved from the dysfunctional to the functional range of behaviour. Table 1 is a summary of the subject's results.

Convergent evidence for a positive increase in self-concept was obtained when the subject's score changed 5 STEN points on Factor O on the CPQ (Table 2) because both Piers-Harris and CPQ Factor O scores have been shown to be highly correlated (Karnes & Wherry, 1982).

These results led to a rejection of the hypothesis as stated in the Null form. Self-concept had changed as measured by this scale.

Table 1

Summary of Scores from Piers-Harris Self-concept Scale

Administration Period	Total Scores			
	Raw Score	Percentile	Stanine	T-score
Pre-treatment	38	17	3	39
Post-treatment	79	99	9	79
Follow-up	76	99	9	75

Third Hypothesis

Anxiety on the CPQ is identified as a second order factor. The contributing factors are C, H, O, and Q4. There was a change of two or more STEN scores on Factors C,H, and O (Table 2).

Table 2

Summary of CPQ Scores

Dimension STEN Scores	STANDARD TEN SCORES (STEN) Pre	Post	Follow-up	Dimension
A.Reserved	1	3	3	Outgoing
B.Concrete thinking	4	5	4	Abstract thinking
C.Ego-weakness	1	4	4	Ego strength
D.Phlegmatic	1	2	4	Excitable
E.Obedient	1	2	1	Assertive
F.Sober	1	5	5	Happy-go-lucky
G.Expedient	4	2	3	Conscientious
H.Shy	1	4	4	Venturesome
I.Tough minded	6	1	1	Tender minded
J.Vigorous	4	1	4	Doubting
N.Forthright	4	3	3	Schrewd
O.Placid	6	1	1	Apprehensive
Q3.Casual	1	3	1	Controlled
Q4.Relaxed	5	3	4	Tense

Note. The mean of a STEN score is 5.5 and the standard deviation is 2. Pre-treatment and follow-up data is from CPQ, Form A, Part 1. Post-treatment data is from CPQ, Form B, Part 1.

Overall, the level of anxiety proneness remained much the same throughout the assessment and follow-up period (Table 3).

Table 3

Summary of Second Order Factors (CPQ)

	Extraversion	Anxiety	Tough Poise	Independence
Pre	3	6	6	2
Post	4	5	7	2
Follow-up	7	6	5	4

The anxiety score on the Piers-Harris was at the first percentile for the pretest. By the posttest session, the anxiety level was at the 99th percentile. The subject responded with more "no" responses to the items which loaded on the anxiety factor during the later data collection periods.

Results showed that the subject's acceptance of anxiety on the Semantic Differential measure changed from a baseline with a mean score of 1 to a mean score of 4.9 as treatment proceeded. Individual scores ranged between 4 and 6. At follow-up, the score was 7 (Figure 1).

Other continuous measures of anxiety based on the Semantic Differential revealed similar results. Problem severity (Figure 2) and Coping effectiveness (Figure 3) showed immediate reduction with the onset of treatment.

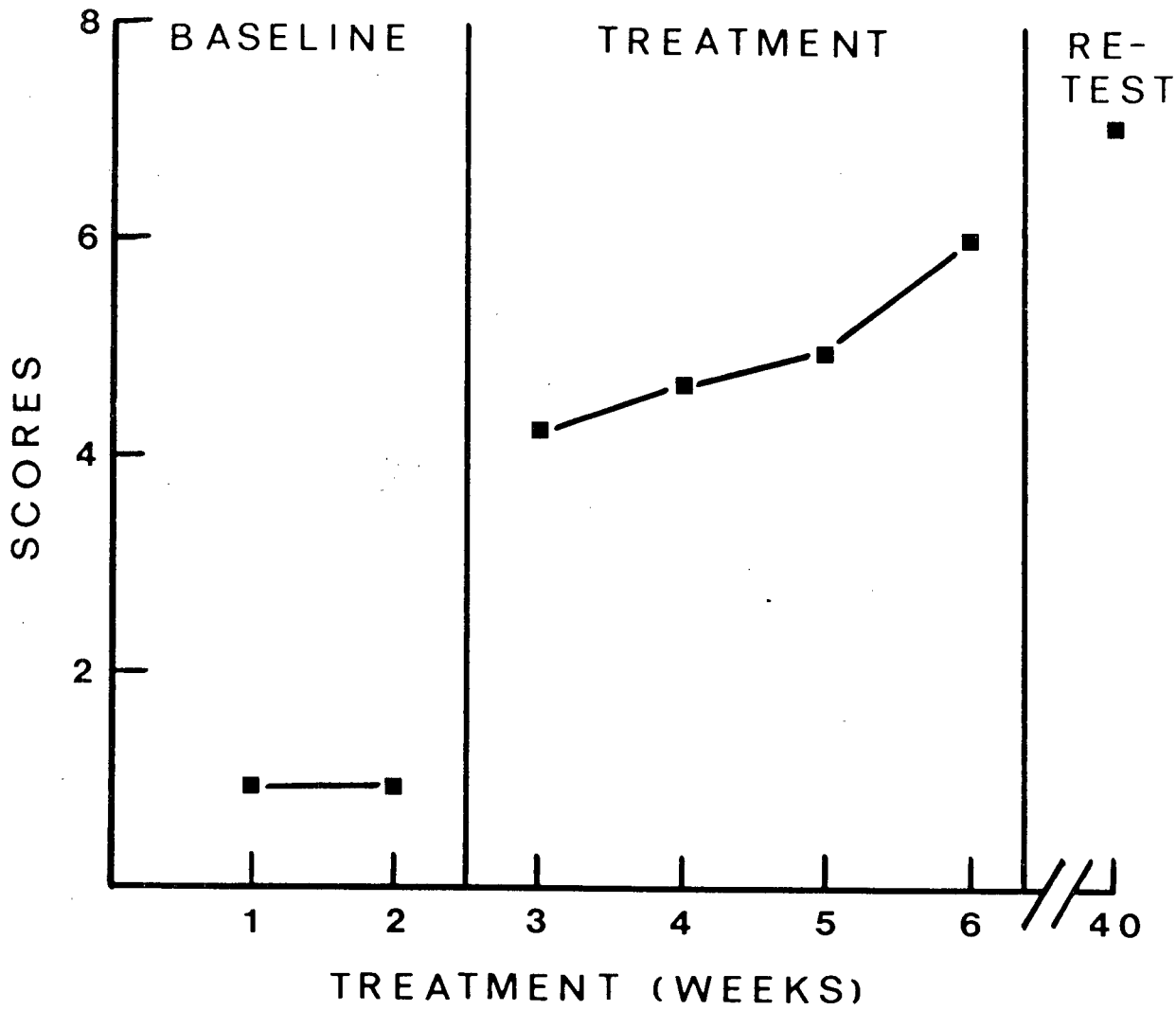

Figure 1. Anxiety Acceptance as measured by the Semantic Differential Technique.

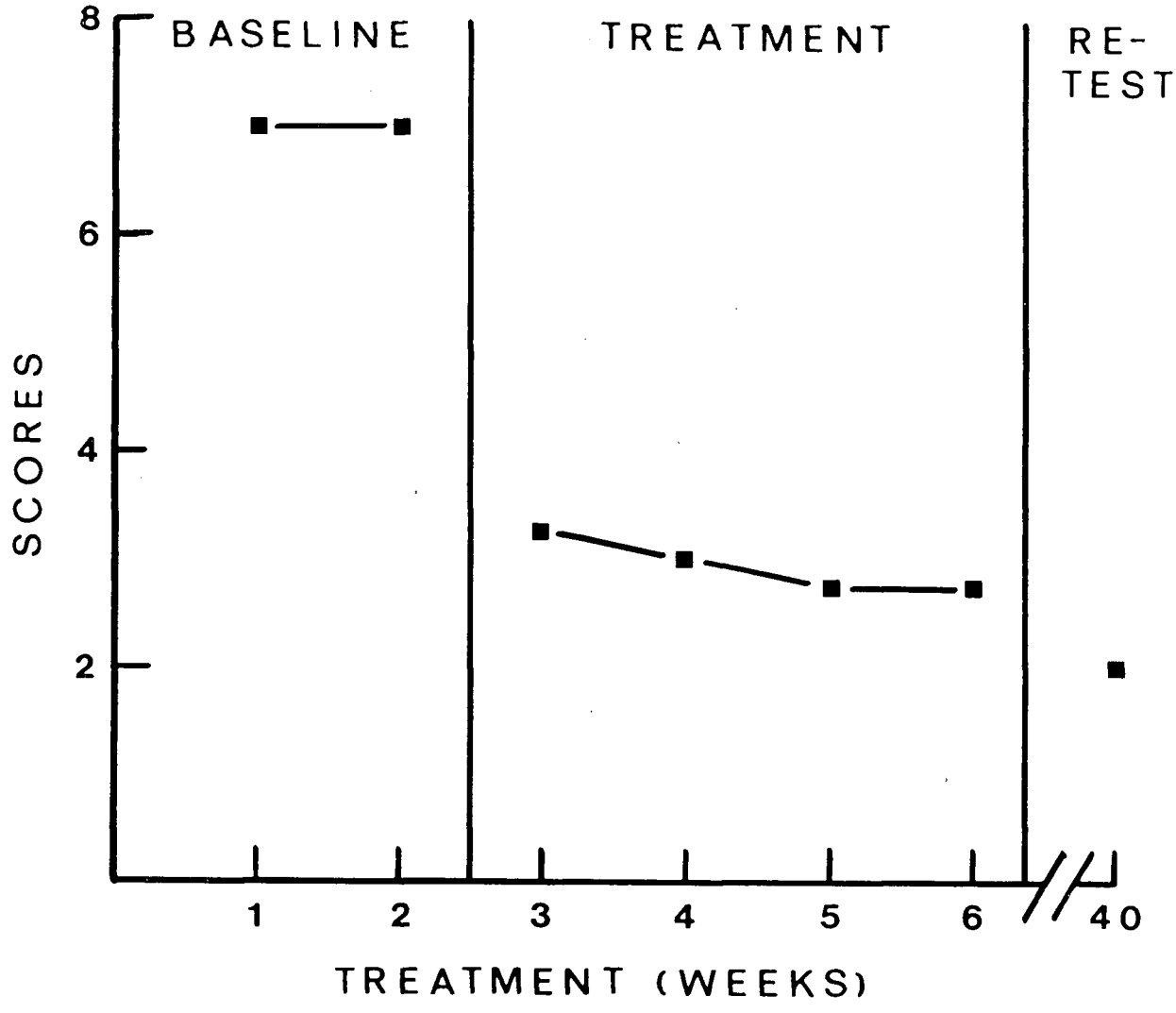

Figure 2. Problem Severity as measured by the Semantic Differential Technique.

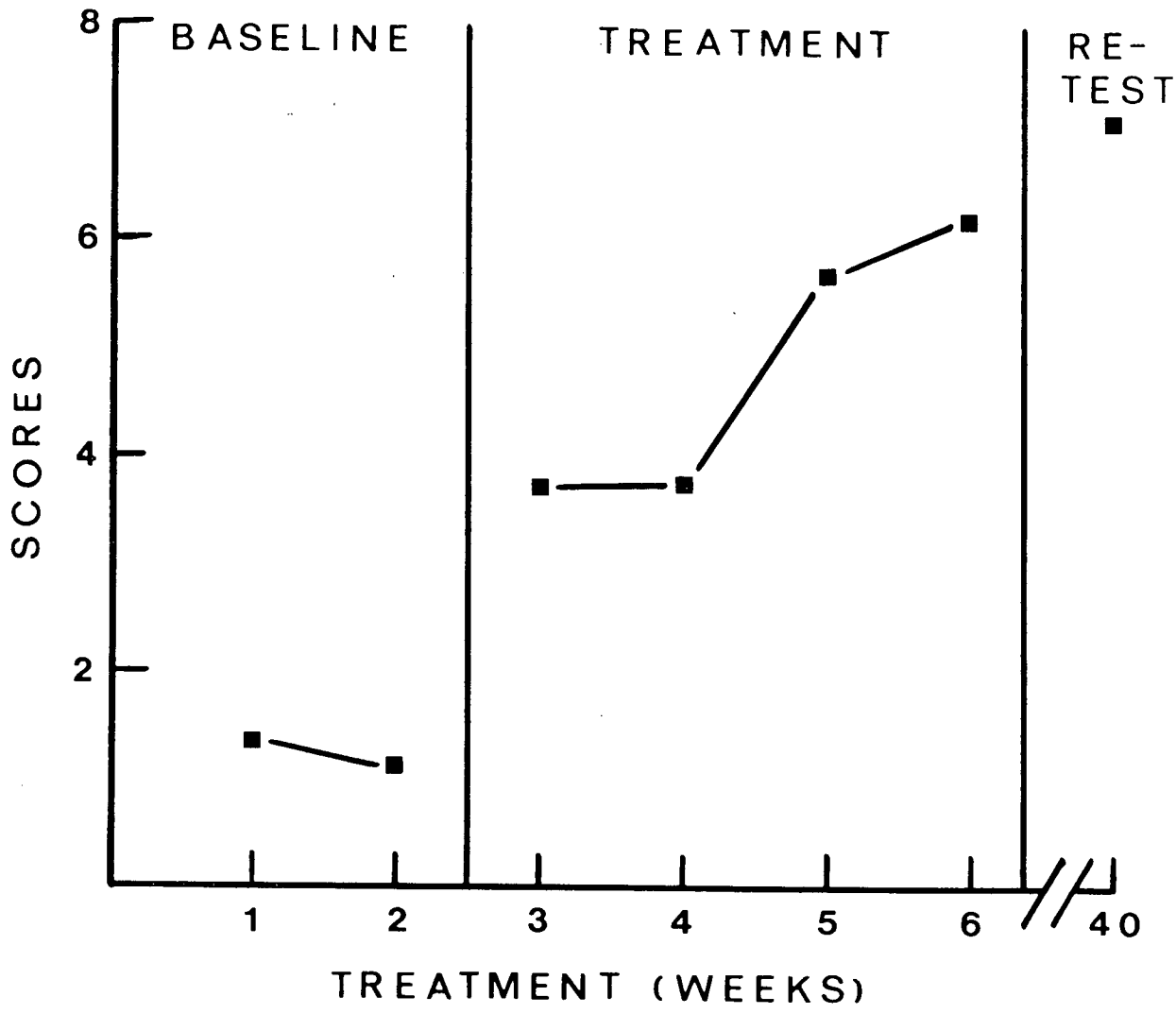

Figure 3. Coping Effectiveness as measured by the Semantic Differential Technique.

In the former assessment, the baseline was a mean score of 1 and the treatment was a mean score of 5.1. The latter was a baseline mean of 1.2 and a treatment mean of 4.9. In each case the follow-up score was 7.

The data from subject identified stressors called Personal Stress Level are graphed in Figures 4, 5, and 6. The subject rated his anxiety about school, social concerns and anxiety in general (everything). In each case, change occurred immediately and visual analysis showed the lessening of reported concern. Each follow-up score was less or equal to the score at the posttreatment session.

There were the changes on anxiety measures which led to a rejection of the hypothesis.

Fourth Hypothesis

Somatic complaints lessened according to parent report and the subject's rating on the sections of The Personal Stress Level that pertain to the somatic complaints of sleep disturbance, headaches and stomach aches (Figure 7). The hypothesis that there would be no change in somatic complaints was rejected.

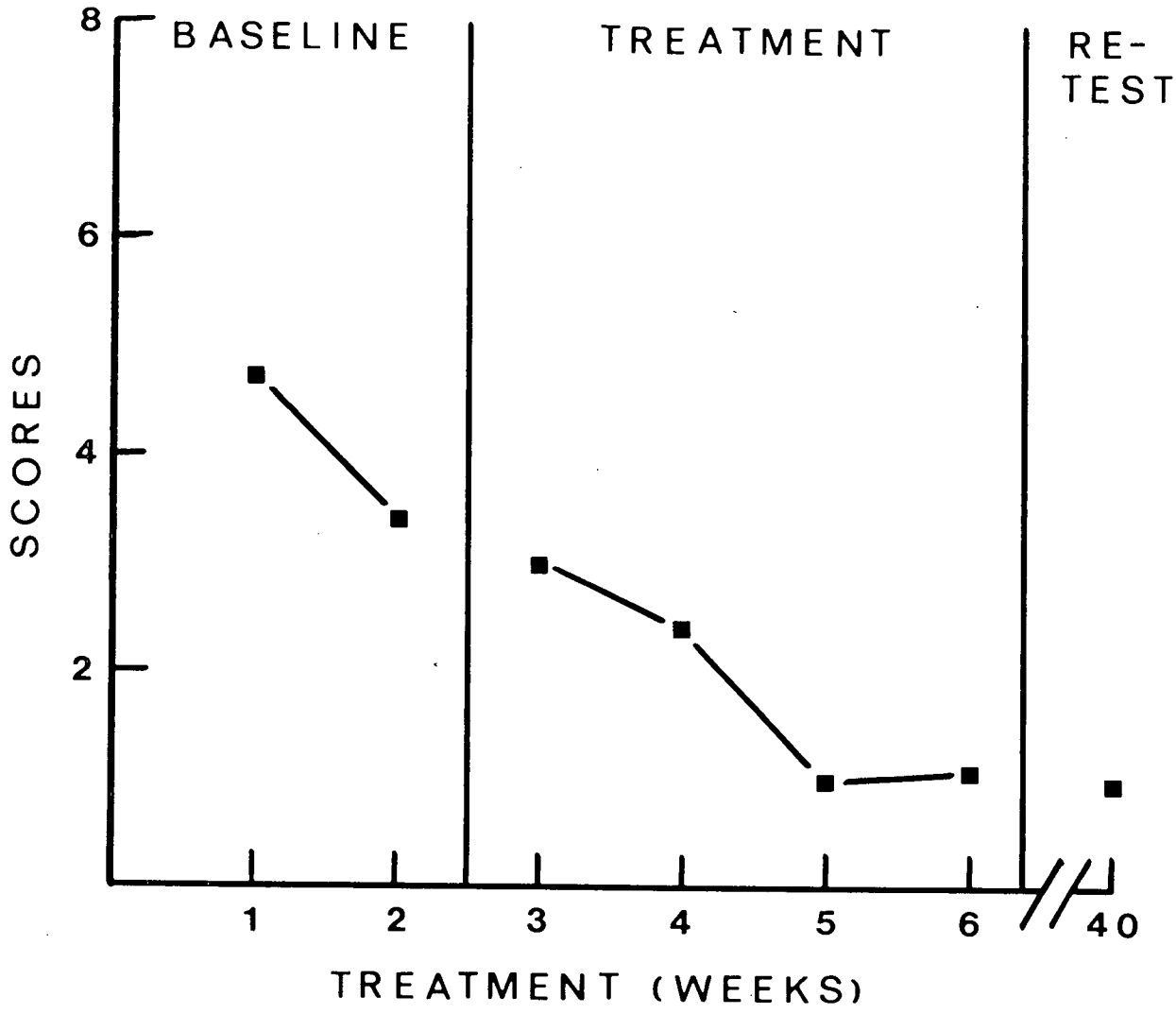

Figure 4. Anxiety About School from the Personal Stress Level Self-Report Measure.

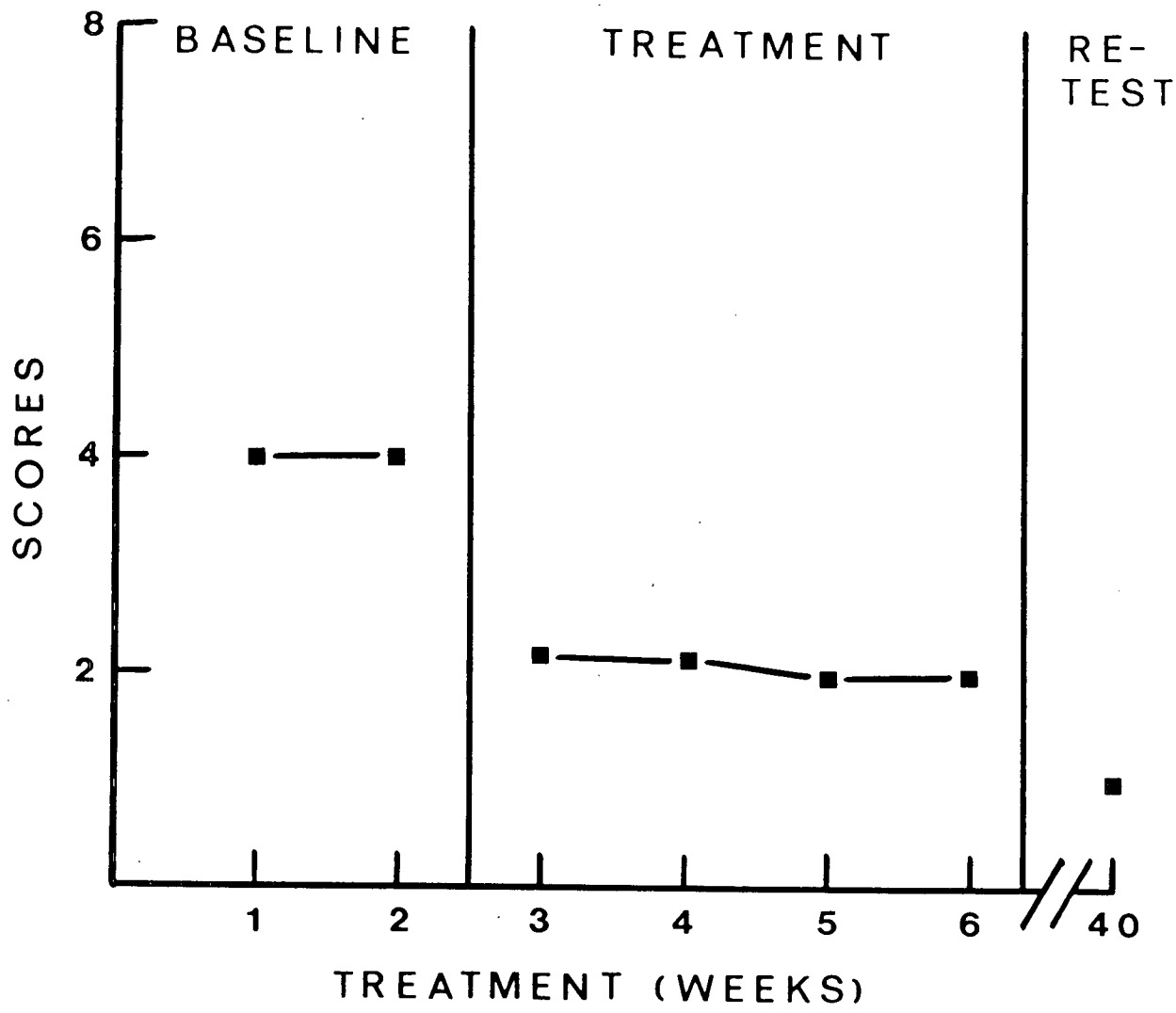

Figure 5. Social Concern from the Personal Stress Level Self-Report Measure.

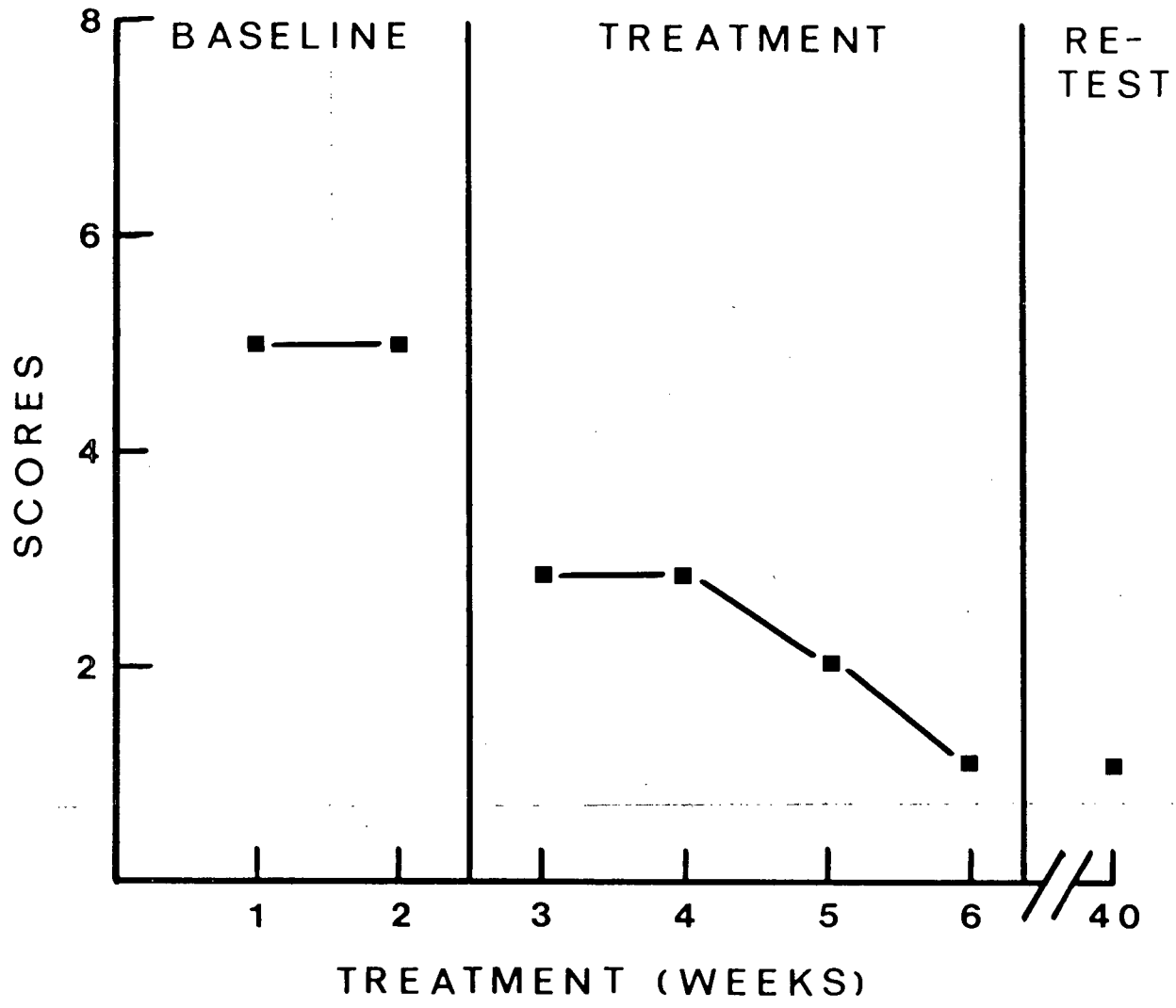

Figure 6. Anxiety About Everything from the Personal Stress Level Self-Report Measure.

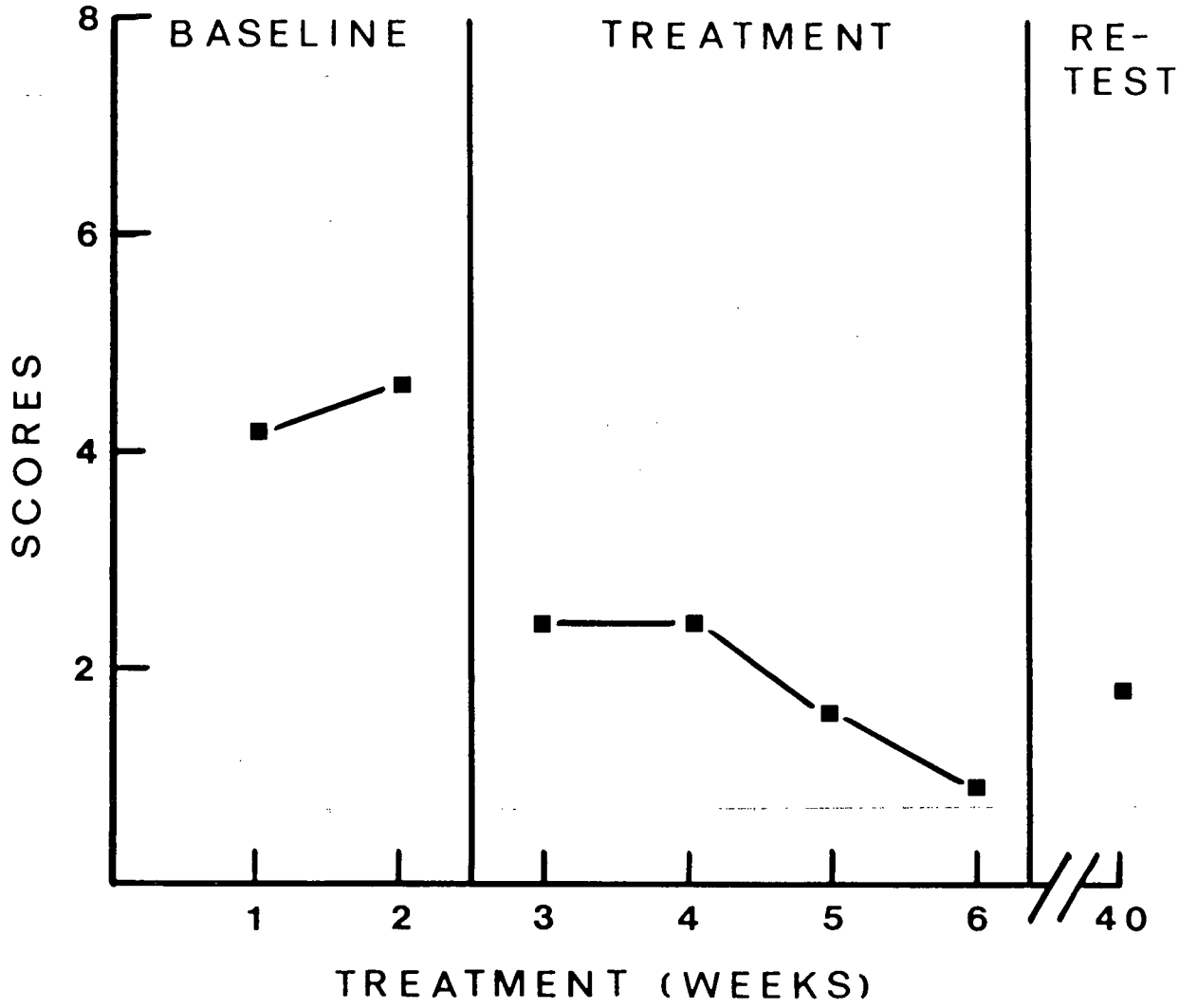

Figure 7. Somatic Complaints from the Personal Stress Level Self-Report Measure.

CHAPTER 5 DISCUSSION

INTRODUCTION

The general purpose of this case study was to provide evidence for the efficacy of hypnosis as a therapeutic intervention for school refusal. Hypotheses, written in the Null form, made statements of no change in school refusal behaviour, self-concept, anxiety, and somatic complaints. Specified continuous self report as well as pre, post, and follow-up assessment scores provided the criteria for change. Both statistical and visual analyses were used to assess impact and each hypothesis was rejected.

THE MAIN HYPOTHESIS

Hypnosis appears to be an effective treatment for this subject's school refusing behaviour. Success of treatment can be evaluated, in part, by how well the child learns to behave in ways appropriate to his/her chronological age (Roberts & Nelson, 1984). The subject returned to school, remained in school for the last two months of the school year and returned to school in Grade 6 in September. During the summer, he was confident enough to enter and win a tennis tournament at his local club. Observations and data of this kind indicate the general impact level of the treatment (Kendall & Braswell, 1982) which answers the question, "Does treatment have a conspicuous impact?" (p. 21). In this case, the answer has to be "yes" because without the intervention, it is unlikely that the subject would have

returned to school (Hersov & Berg, 1980).

Specifying levels of assessment are also important because this is how we can determine exactly what did and did not change. In this study, indices of the subject's reported stressors and his subjective evaluations of school-related anxieties charted the progressive change as treatment was pursued. Parent report substantiated the disappearance of the school refusal behaviour.

SELF-CONCEPT

Significant changes in self-concept as measured by The Piers-Harris Self Concept Scale were reported. The changes were unimpaired by time because follow-up results remained at the same level as the post-treatment scores. Scores between the 31st and 70th percentile are considered average however higher scores have been interpreted to reflect a positive self-evaluation or a healthy desire to look good in front of others (Piers, 1984). The changes for the subject were pervasive across the six areas of evaluation, one of which is intellectual and school status. School no longer was a threat to a positive self-concept.

Self-esteem and self-concept are also asserted to be personality characteristics which determine how children handle perceived threats in the school situation because it has been reported that persons with high self-esteem think they can cope with stressful and anxiety provoking events (Hobfall & Walfisch, 1984) and they are less likely to react with avoidance and anxiety to threatening situations. The subject reported

increased ability to cope with school as treatment progressed. As well as significant changes on the Piers-Harris scores, there was a corresponding change on Factor O on the CPQ. There is evidence that these measure the same construct (Karnes & Wherry, 1982) and this lends credibility to the assertion that there has been a change in self concept. Indications are that self concept is related to whether situations are perceived to be stressful or not (Hobfoll & Walfisch, 1984) and when the subject was positive about himself in school, he was not so likely to engage in avoidance behaviour.

ANXIETY

The results indicate that there was a strong change in scores on the anxiety component in The Piers-Harris Children's Self Concept Scale. However, the STEN scores of the second-order factor called "anxiety" on the CPQ were relatively stable. Possibly, this can be explained by examining the equation which was used to compute this second-order anxiety factor because the subject had areas of great change and areas of stability or little change, and interactions among these may have cancelled or masked effects, or the measures may tap into different factors both labelled "anxiety". It also could mean that anxiety, the trait, was stable for this subject and that it would be more meaningful to examine the subject's ratings of his perceived coping ability and stress levels at school. Much empirical research on self concept is based on the assumption that a positive appraisal of one's competence is related to how

the person deals with anxiety producing situations (Nicholls, Jagacinski & Miller, 1980).

The subject's self-reports on anxiety showed significant changes as did his reports of his acceptance of anxiety and his ability to cope. Since anxiety is "a general and lasting emotional state that reflects one's feelings of weakness, ineptitude, and helplessness, anxiety is tantamount to the loss of self esteem" (Wolman, 1984, p. 143). The hypnotic intervention stressed the feelings of well being the subject could experience in the school situation as well as providing training in relaxation techniques, and both of these behaviours are incompatible with stress or anxiety reactions.

SOMATIC VARIABLES

Somatic complaints such as headaches and stomach aches were reduced drastically while disrupted sleep patterns and early morning awakening were virtually eliminated. Reports from the literature indicate that psyche and soma are interrelated. Physical illness may cause psychiatric symptoms and vice versa (Guidano & Liotti, 1983). School refusal is almost always accompanied by somatic complaints which often cover up the syndrome (Waller & Eisenberg, 1980). In this study, a self-report measure on stressful thoughts about sleep, headaches and stomach aches was collected during the baseline, treatment, and follow-up phases. Progressive ratings showed a positive change in all these areas and parent reports confirmed the actual changes did occur.

CONCLUSION

Although personality, anxiety, and self-concept were treated as separate topics in this paper, they were not viewed as discrete entities but as interactions. Conclusions reached about each as regards hypothesis statements must be understood in this light.

Results of this research indicated that the outcome of hypnosis for the treatment of school refusal was a functional change for adaptive behaviour. This was supported by positive changes in self-concept, a lessening of psychosomatic complaints, a return to regular school attendance, and greater ability to cope with anxiety. Both criterion-referenced and normative standards provided confirmation.

One other plausible explanation for the change besides treatment effect is that the interaction between the therapist and the subject made the difference. This variable in therapeutic relationships is difficult to delineate in therapeutic studies (Stiles, Shapiro, & Elliott, 1986). Hypnosis is no exception and one view is that "hypnosis is a 'dual phenomenon' occurring within the context of an intense interpersonal relationship" (Diamond, 1984, p. 3). In other words, the subject and the hypnotist can be viewed as a unit (Diamond, 1987). Nonspecific factors, such as perceived therapy credibility and therapist attention and support, are seen as effective but not sufficient as an explanation for the change which occurred (Spinhoven, 1988, p. 190). More process research is needed to explicate the mechanisms of therapist involvement

as a causitive agent for change.

What may be an important concept in the exploration of critical factors in the school refusing personality profile is the relationship to and the effect of anxiety on self-concept. In this case study, as the subject rated his ability to cope higher, problem severity decreased and anxiety acceptance increased. Treatment content, under hypnosis, dealt directly with being confident and coping in the school situation. Implications from this research would suggest that it may be worthwhile to investigate the effect of this type of hypnotic intervention on self-concept in other types of anxiety disorders in children.

Since this is a single case study, results are not generalizable yet several questions are raised in regard to necessary variables in the recognition and treatment of school refusal. This study provided statistical as well as clinical evidence for the effectiveness of hypnosis in the treatment of school refusing children. More research is needed to answer questions regarding the mechanisms of this procedure, to define the outcome success standards and examine the relationship of self-concept, anxiety,and school refusal - not only for its treatment implications but also for proactive considerations.

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Appendix A

PERSONAL STRESS LEVEL

	Least Stressful				Most Stressful
1.Sleep	1	2	3	4	5
2.Going to sleep	1	2	3	4	5
3.Upset stomach	1	2	3	4	5
4.Gas pains	1	2	3	4	5
5.Going to school	1	2	3	4	5
6.Being in classroom	1	2	3	4	5
7.Doing math in class	1	2	3	4	5
8.Doing reading comprehension in class	1	2	3	4	5
9.Taking a test	1	2	3	4	5
10.Feeling accepted in class	1	2	3	4	5
11.Feeling inadequate and unsure in class	1	2	3	4	5
12.Playing with close friends	1	2	3	4	5
13.Playing with other students	1	2	3	4	5
14.Doing homework	1	2	3	4	5
15.Worry about everything (Nothing specific)	1	2	3	4	5

Appendix B

1. Anxiety Acceptance Scale ("My anxious nature...")

a) Acceptable _____ Unacceptable

b) Useful _____ Useless

c) Desireable _____ Undesireable

2. Problem Severity Scale ("My anxiety problem is...")

a) Manageable _____ Unmanageable

b) Easy to solve _____ Hard to solve

c) Bearable _____ Unbearable

3. Coping Effectiveness Scale

("I feel... in dealing with the problem.")

a) Competent _____ Incompetent

b) Hopeful _____ Hopeless

c) Patient _____ Impatient

d) Self-accepting _____ Self-critical

e) Objective _____ Emotional

f) Clear minded _____ Confused

g) Self confident _____ Unsure

h) Relaxed _____ Tense

(Ishiyama, 1986)

Appendix C

Trance Induction

(This induction can take from 10 to 15 minutes.)

"Make yourself as comfortable as you can...allow your muscles to relax...close your your eyes if you want to...feel the sensations, warm and relaxing...allow them to drift down and down...allow the music and my voice and any surrounding sounds to become part of your comfort and relaxation...take a deep breath and gradually release all the tension and stress from your body system...take in the oxygen so that every body cell will be revitalized, energized...each time you exhale, let all the tension and stress leave your body...and let the music make you feel more and more relaxed...drifting...drifting...you may feel certain sensations...allow them to become more comfortable, more relaxed...as all parts of your body can become more restful, more limp...with each breath you may notice your body is beginning to feel more and more relaxed, more and more calm...allow yourself to feel the sensations of relaxation in your muscles, in your chest, in your arms, in any part of your body...consciously you don't need to pay attention to all the things I'm saying to you because consciously you may be thinking of other things or fantasizing about something else ... your unconscious mind will understand and remember the things I'm going to talk about and your unconscious mind will utilize the things I'm going to be talking about, for your own benefit ... I'll count from five backwards to one and you can drift deeper

and deeper, more and more relaxed ..5.. inhaling ... exhaling ..4.. drifting down ..3...2.. allow yourself to drift a little deeper ... breathing very regularly ... heart rate is normal ... all the internal functions are normalized ..1.. and relax.

Pleasant Scene

(The subject was asked to think of a pleasant scene or activity before the trance induction. The therapist should use the words and adjectives supplied by the subject to describe the scene or activity to help him visualize and experience it more fully.) "Imagine you're at a beautiful place ... fresh air ... nice breeze ... birds in the distance ... enjoy the sensations of comfort ... breathe in the fresh air and let it revitalize and energize your whole body system ... let your body absorb all the energy ... enjoy your quiet, peaceful surroundings ... feel the warm sun on your face and your shoulders ... let those feelings within you of peace and confidence and calmness fill your body ... allow them to reenergize those positive feelings within you ... you may not hear all the things I'm saying ... you may be listening to the waves rolling onto the beach ... or you may be thinking of something else ... your unconscious mind will remember ... now spend a few minutes enjoying your beautiful surroundings ... I will be quiet for a few moments so you can enjoy your safe, peaceful, relaxing place ... (Therapist remains silent for 2-4 minutes).

Cognitive Restructuring

"Now its time to leave this pleasant scene but remember as you go that this is your place and you can return here any time you wish ... so lets return to the office ... still enjoying the sense of relaxation and peacefulness ... comfortable, confident feelings ... look around the office until you see the TV screen ... tell me what you see on TV ... I want you to visualize on that screen a situation which caused you discomfort or anxiety ... picture yourself in that situation ... and how are you feeling ... how does your body feel at that moment ... what are you doing in that situation ... tell me as soon as you have completed watching and listening, with comfort and security, to this behaviour that you want to change ... (wait until you get a "yes" response) ... do you know what new behaviour you would prefer to make in this situation ? ... good, now watch and listen to yourself as you make the new response in the situation that used to be a problem for you ... give me a "yes" response when you're done ... this time I want you to watch yourself on the computer ... put yourself on the screen and feel what it is like to carry out those new behaviours in school ... does it still feel good ? ... give a "yes" response when it feels completely comfortable and like you ... will you, his unconscious mind, take responsibility for having this new behaviour actually occur in the context where the old behaviour used to occur ? ... now give me a "yes" response as soon as you, his unconscious mind, have discovered what specifically you'll see, hear, or feel, that will indicate that this is a context

where you are going to make this new behaviour occur ... alright, now I want you to return to your pleasant scene, and all the feelings of comfort and relaxation and calmness you feel there ... feel the sun and the light breeze ... allow the fresh air to refresh and revitalize you...allow yourself a few moments to feel all the positive sensations there ... "

Much of the text in this section is taken from Grinder & Bandler, 1981,pp. 178-182.

(The therapist works through one or more situations with the client. As therapy progresses, the subject may volunteer more information, requiring fewer questions from the therapist. It is important to obtain "yes" and "no" answers because the feedback must be unambiguous).

Termination of Formalized Trance

"Now I'm going to count from one to five and as I do so you will begin to slowly wake up and as I'm counting you don't have to listen to me consciously because your unconscious will remember to forget what it wants to forget and remember as much as your conscious mind wants you to ..1.. you'll feel comfortable and relaxed ..2.. as I count you can begin to open your eyes ..3.. still felling relaxed and positive ..4...5.. when you're ready, you can open your eyes ... feeling refreshed and relaxed."

(Following trance, the subject may wish to review the events which took place and discuss the situation or situations).

Appendix D

Significant change can be assessed in a single subject by assessing the difference between pretest and posttest (obtained) score. The formula developed to do this is as follows:

$$SC = \frac{X2 - X1}{S\ diff}$$

where

SC = significant change

X1 = pretest score

X2 = posttest score

S diff = standard error of difference between two test scores.

(Christensen & Mendoza, 1986, p. 306)